

**California State Board of Pharmacy**

400 R Street, Suite 4070, Sacramento, CA 95814-6237

Phone (916) 445-5014

Fax (916) 327-6308

Website - www.pharmacy.ca.gov

STATE AND CONSUMER SERVICES AGENCY

DEPARTMENT OF CONSUMER AFFAIRS

ARNOLD SCHWARZENEGGER, GOVERNOR

CHANGE OF EXEMPTEE-IN-CHARGE

Both the exemptee-in-charge and the owner of a wholesaler or veterinary food-animal drug retailer are required by California law to notify the Board of Pharmacy within 30 days after the termination of the exemptee-in-charge. Failure to make this notification to the board may result in a citation and fine or other disciplinary action.

To properly notify the board of a change in exemptee-in-charge, the following items must be submitted:

- Completed Change of Exemptee-in-Charge form
- \$60 fee (excluding government-owned facilities)
- Individual Certification Affidavit for NEW exemptee-in-charge only

(Please print or type)

ALL SECTIONS MUST BE COMPLETED

Name of wholesaler or veterinary food-animal drug retailer:	Telephone	Permit number
Address : Street	City	State Zip
List below the name, license number and address of the new exemptee-in-charge:		
Name	Exemptee license number	
Home address Street	City	State Zip
Effective date		
List below the name, license number and address of the exemptee-in-charge being replaced:		
Name	Exemptee license number	
Home address Street	City	State Zip
Date of disassociation		

I certify under penalty of perjury under the laws of the State of California to the truth and accuracy of all statements, answers and representations made in the foregoing.

Signature of owner, partner or corporate officer_____
Typed or printed name and title_____
Date_____
Signature of new exemptee-in-charge_____
Date_____
Signature of exemptee-in-charge being replaced
(if available)_____
Date

Cashier # _____

Date _____

Amount _____



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INDIVIDUAL CERTIFICATION AFFIDAVIT

All blanks must be completed; **if not applicable enter N/A**. Failure to furnish a complete explanation or any omissions will delay the processing of your application.

Please print or type

Full name: Last First Middle			Residence telephone: ()	
Previous name(s) – include maiden name, also known as (AKA's), "aliases":			*Social Security number:	
Residence address: Number and Street		City	State	Zip
Date of birth: (Month, Day, Year)		Place of birth: (City, State, Country)		

Name and address of current employer:		
Work telephone:	Present occupation:	Professional or vocational licenses held: (Specify type and number)

Spouse's name: Last First Middle		
Spouse's Date of Birth:		Spouse's Social Security Number:
Will your spouse work in any capacity under the permit? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Name of applicant premises:		Applicant telephone number:	
Address of applicant premises: Number and Street		City	State Zip

My position with the applicant is: (Check all that apply)			
<input type="checkbox"/> Sole owner <input type="checkbox"/> Partner	<input type="checkbox"/> Officer <input type="checkbox"/> Stockholder _____%	<input type="checkbox"/> Director <input type="checkbox"/> Financier/lender	<input type="checkbox"/> Manager <input type="checkbox"/> Other - Specify: _____

1. Do you have, or have you had in the last 5 years, any direct or indirect beneficial interest in any other premises licensed by any board of pharmacy? Yes No

If yes, list current direct or indirect beneficial interests (use an additional sheet if necessary). Include sites licensed in states other than California.

Name	Address	Permit Number	Dates: From/To
Name	Address	Permit Number	Dates: From/To
Name	Address	Permit Number	Dates: From/To

2. Are you currently or have you previously been listed as a corporate officer, partner, owner, manager, member, administrator or medical director on a permit to conduct a pharmacy, wholesaler, medical device retailer, veterinary retailer or any other entity licensed in this state or any other state? Yes No

If the answer is "yes," please list the company name, permit type and number, position(s) held, state and expiration date. Please include cancelled permits. (Use additional sheets if necessary.)

Name of Company	Type of permit	Permit number	Position held	State	Expiration date

3. Have you ever had a permit or any professional or vocational license or registration denied, suspended, revoked, voluntarily surrendered, placed on probation or other disciplinary action taken by this or any other governmental authority in this state or any other state or by a federal regulatory agency? Yes No

If the answer is "yes," please provide company name, permit type, action, year of action and state. (Use additional sheets if necessary.)

Name of person or company	Type of permit	Type of action	Year of action	State

4. Have you ever been in violation of any provisions of pharmacy law? Yes No

If "yes," please list each type of violation, license type, type of action, year of action and state. (Use additional sheets if necessary.)

Type of violation	License type	Type of action	Year of action	State

5. Are you currently or have you previously been associated in business with any person, partnership, corporation or other entity, or shared a financial or community property interest with any person whose permit or any professional or vocational license was denied, suspended, revoked, or placed on probation or other disciplinary action taken by this or any other governmental authority in this state or any other state or by a federal regulatory agency?

Yes No

If the answer is "yes," please list the company name, permit type, action, year of action and state. (Use additional sheets if necessary.)

Name of person or company	Type of permit	Type of action	Year of action	State

6. Please describe if any of the above actions with spouse or an individual with whom you have a personal ownership interest in real property. _____

7. Have you ever been convicted of, or pled no contest to, a violation of any law of a foreign country, the United States or of any state or local ordinances? You must include all **misdemeanor and felony convictions**, regardless of the age of the conviction, **including those** which have been set aside and/or dismissed under Penal Code sections 1000 or 1203.4. (Traffic violations of \$500 or less need not be reported.)

Yes No

If "yes," please attach an explanation which must include the type of violation, the date, circumstances and location, and the full penalty received.

8. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety without exposing others to significant health and safety risks?

Yes No

If you marked "no" to question 8, please go directly to question 10.

9. Are the limitations caused by your medical condition reduced or improved because you receive ongoing treatment or participate in a monitoring program?

Yes No

If "yes," please attach a statement of explanation.

(If you do receive ongoing treatment or participate in a monitoring program, the board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, or whether conditions should be imposed).

10. Do you currently engage in, or have been engaged in the past two years, in the illegal use of controlled substances?

Yes No

If "yes," are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled substances? Please attach a statement of explanation.

11. Will you work as an employee of this business?

Yes

No

If yes, what will your responsibilities and duties be with this business? _____

12. Current and past employment for at least the past five years. (Use additional sheets if necessary.)

From (month/year)	To (month/year)	Type of work	Firm name and city

Please read carefully and sign below.

I understand that falsification of the information on this form may constitute grounds for denial or revocation of the license.

I hereby certify under penalty of perjury under the laws of the State of California to the truth and accuracy of all statements, answers and representations made in the foregoing individual personal affidavit, including all supplementary statements and I personally completed this personal affidavit.

Applicant's signature	
Title	Date
Place	Attest (Notary Public)

*Disclosure of your social security number is mandatory. Business and Professions Code section 30 and Public Law 94-455 (42 USCA 405(c)(2)(C) authorize collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes of compliance with any judgement or order for family support in accordance with section 11350.6 of the Welfare and Institutions Code, or for verification of examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number, your application for initial or renewal license will not be processed AND you will be reported to the Franchise Tax Board, which may assess a \$100 penalty against you.